

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28528

FILED SEP 13 1948 55

Primary Registration District No. 4244

Registrar's No. 10

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carterville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
 210 Elm St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 1.5 yrs.
years, months or days

3. (a) PRINT FULL NAME Edith May Turner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced /

6. (b) Name of husband or wife Edith May Turner

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased June 3 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 19 If less than one day _____ hr. _____ min

9. Birthplace Lawrence Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name P. B. Gaskins

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Edith May Kennedy 9

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. M. Brooks

(b) Address Station 2, Mo.

17. (a) Burial (b) Date thereof Aug. 25 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director W. H. Clark & Co.

(b) Address W. H. Clark & Co.

19. (a) Aug. 25, 1948 Mrs. Lillie Lyle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 43

(c) City or town Carterville 0
(If outside city or town limits, write "RURAL")

(d) Street No. 210 Elm St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22
year 1943 hour 8.5 minute 0 M.

21. I hereby certify that I attended the deceased from Jan. 21
 1943 to Aug. 22 19 43

that I last saw her alive on Aug 21 19 43

and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Hypertrophic Arthritis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 93e1

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 9

23. Signature J. M. Lane 20 (M. D. or other)

Address Carterville Mo Date signed 8/24/43

1180

48-8-702

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[Faint handwritten notes]

[Faint handwritten notes]

[Faint handwritten notes]

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by myself

..... Registered Apprentice No.
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Hebb City Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING; (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.